Within corporate limits

DR. W.F.WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18-a

03300

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 4 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINIA County HAMPSHIRE
City or town Near ROMNEY, rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war World War I

3.(a) FULL NAME H.
BERNARD ALT

3.(b) Social Security Number 217-10-9034

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife ROSE A. GOETZ
6.(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) SEPT. 14, 1889

8. AGE: Years 56 | Months 7 | Days 10 | If less than one day ... hrs. ... min.

9. Birthplace Petersburg, Grant County, W. Va.
(Town, county, and state)

10. Usual occupation Electrician

11. Industry or business Potomac Edison

FATHER
12. Name ABEL ALT
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden name SOPHRONIA IMAN
15. Birthplace WEST VIRGINIA

16. Informant Mrs. B. Alt
Address Romney, W. Va.

17. Burial (Burial, cremation, or removal? Which?) Date thereof April 27, 1946 (month) (day) (year)
Cemetery or crematory Indian Mound Cem.
Location Romney, W. Va.

18. Funeral director Shrush's
Address Romney, W. Va.

19. April 25, 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24, 1946 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APR. 20, 1946, to APR. 24, 1946 and that I last saw h... im alive on APR. 24, 1946

	DURATION
Immediate cause of death Cardio Vascular renal disease ?	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other
Address Cumberland Date signed 4-25-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
APR 30 1946
BUREAU V. R.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

★ 03301

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: W.Va. County: Mineral

City or town: rural near Keyser (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Dorothy Belle Amtower

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Dewey Emory Amtower

6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): May 23, 1922

8. AGE: Years	Months	Days	If less than one day
23	10	12	....hrs. ....min.

9. Birthplace: Burlington, Mineral Co. W.Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER — 12. Name: Harry Fisher Shank

FATHER — 13. Birthplace: Burlington, W.Va.

MOTHER — 14. Maiden name: Ida Grace Kelly

MOTHER — 15. Birthplace: Burlington, W.Va.

16. Informant: Dewey Emory Amtower

Address: R#1, Box 37A, Keyser, W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-8-46 (month) (day) (year)

Cemetery or crematory: Meadow Point Cemetery

Location: Keyser, W.Va.

18. Funeral director: N.L. Rogers Funeral Directors

Address: Keyser, W.Va.

19. April 8, 1946 (Date rec'd by registrar) J.L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5, 1946, at 8:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20, 1946, to April 5, 1946 and that I last saw her alive on April 5, 1946

Immediate cause of death	DURATION
Obstruction Suture	
Due to Sigmoid Diverticulitis	
Due to Colon Gangrene	
Other conditions Do not know Cause	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: A.H. Hawkins M. D. or other

Address: Cumberland, Md. Date signed 4-8-46

RECEIVED
APR 16 1946
BUREAU V. R.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

03302

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

911 Ridgedale Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 911 Ridgedale Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Zetta Irene "Alkire" Arthur

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Bill Arthur

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Sept 30, 1895

8. AGE: Years	Months	Days	If less than one day
50	6	11	hrs. min.

9. Birthplace: Cumberland, Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER 12. Name: Wade Alkire

13. Birthplace: W.Va.

MOTHER 14. Maiden name: Adeline Robinette

15. Birthplace: Oldtown, Md

16. Informant: Bill Arthur

Address: Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 17, 1946 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Md

18. Funeral director: John J. Hofer

Address: Cumberland, Md.

19. April 16 1946 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11 1946, at 12:20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 12 1946 to April 11 1946 and that I last saw h. alive on April 11 1946

Immediate cause of death	DURATION
Carcinoma of Breast	8 Mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address 126 Union St Cumberland Md Date signed 4/13/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
APR 18 1946
BUREAU V.S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (89-a)

CERTIFICATE OF DEATH

03303

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 yrs
Hospital, institution, or street address where death occurred:
Brunswick Hotel
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Brunswick Hotel
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Wesley W. Ayers

3.(b) Social Security Number: 188-22-3567

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 4, 1900

8. AGE:

Years	Months	Days	If less than one day
45	9	18	hrs. min.

9. Birthplace: Cumberland, Allegany, Md
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Laundry Machine Operator
FATHER 12. Name: Wesley Ayers
13. Birthplace: Virginia
MOTHER 14. Maiden name: Mary L. Painter
15. Birthplace: Cumberland, Md.
16. Informant: Mrs. Margaret Mauk
Address: 232 5th St, Conemaugh, Pa.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 27, 1946 (month) (day) (year)
Cemetery or crematory: Zion Memorial Park
Location: Cumberland, Md.
18. Funeral director: John J. Hofer
Address: Cumberland, Md.
19. April 27 1946 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Probably about April 22nd, 1946, at 10P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage (apoplectic Stroke)	
Due to	
Due to	
Other conditions: body decomposed when found.	

(Include pregnancy within 3 months of death)

Major findings of operations: -----
Date of op.
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Bruce H. Brown, M. D.
M. D. or other
Address: Cumberland, Maryland Date signed: 4-25-46
Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

RECEIVED
APR 30 1946
BUREAU U. S.

Within corporate limits

Evidence for change of birth date of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-D)

CERTIFICATE OF DEATH

03304

Reg. Diat. No. 4

FILM No. 104 MAY 10 1946

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Day

Hospital, institution, or street address where death occurred:

111 West Elder St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Oldtown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James Russell Bartlett

3.(b) Social Security Number: 722-18-6999

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Oma Bartlett

6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): December 26, 1910

8. AGE:

Years	Months	Days	If less than one day
35	4	6	...hrs. ...min.

9. Birthplace: Oldtown, Allegany Co, Maryland (Town, county, and state)

10. Usual occupation: Machinist Helper

11. Industry or business: B & O R R.

FATHER

12. Name: Louis Bartlett

13. Birthplace: Oldtown Md

MOTHER

14. Maiden name: Lillie Melott

15. Birthplace: Spring Gap, Md.

16. Informant: Mrs Oma Bartlett

Address: Rural Oldtown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/2/46 (month) (day) (year)

Cemetery or crematory: Mt. Tabor

Location: Spring Gap, Md

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. May 7, 1946 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29 1946, at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 29 1946 to April 29 1946 and that I last saw him alive on April 29 1946

Immediate cause of death	DURATION
Chronic Myocarditis	5 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: J. L. Franklin M.D.

M. D. or ...

Address: Cumberland, Md. Date signed: 4-30-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
MAY 3 1946
BUREAU V.R.

Within corporate limits

Dr. C. L. OWENS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (572)

CERTIFICATE OF DEATH

03305

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPTIAL

How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State PENNA. County SOMERSET

City or town BERLIN
(If outside city or town limits, write RURAL and give nearest town)

Street No. RT #1
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME BAUGHMAN, JOHN E. (BABY)

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 12, 1946

8. AGE: Years | Months 3 | Days 24 | If less than one day ... hrs. ... min.

9. Birthplace PENNA.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name BAUGHMAN, EDISON C.

FATHER 13. Birthplace PENNA.

MOTHER 14. Maiden name CUSTER, EVELYN

MOTHER 15. Birthplace PENNA.

16. Informant Edison Baughman

Address Berlin, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 8 1946 (month) (day) (year)

Cemetery or crematory Old Bellair Cemetery

Location Berlin, Md.

18. Funeral director Johnson & Son

Address Berlin, Md.

19. April 6 1946 (Date rec'd by registrar) Joseph O. Franklin M.D. Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH APRIL 6, 1946 19 46, at 8:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 - 1946 to April 6th 1946

and that I last saw him alive on April 6th 1946

Immediate cause of death	DURATION
Congenital Endocarditis	2 hrs
Due to	
Due to Atelectasis Premature	2 hrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. L. Owens M.D.
M. D. or other

Address Cumberland Date signed 4-6-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9945-15M

RECEIVED
APR 9 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

CERTIFICATE OF DEATH

03306

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Callah Still

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Margret Blank

3. (b) Social Security Number: none

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Edward M. Blank

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): June 20-1885

8. AGE: Years: 60 Months: 9 Days: 19 If less than one day: ... hrs. ... min.

9. Birthplace: Eckhart - Alleg - Md. (Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business

FATHER 12. Name: Samuel Dudley

13. Birthplace: Md.

MOTHER 14. Maiden name: Gwendalyn Jeffreys

15. Birthplace: Wales

16. Informant: Edward M. Blank

Address: Mt Savage, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 11-1946 (month) (day) (year)

Cemetery or crematory: Methodist

Location: Mt Savage, Md.

18. Funeral director: J. J. Dunn

Address: Frostburg, Md

19. 4-11 1946 (Date rec'd by registrar) Wm. Davey H Reg. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8 1946, at 4:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 1946, to Apr 8 1946 and that I last saw h... alive on Apr 8 1946

	DURATION
Immediate cause of death: Coronary Thrombosis	5 Days
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: W M Lane Jr MD M. D. or other

Address: Frostburg Md Date signed 4-10-46

RECEIVED
APR 13 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

CERTIFICATE OF DEATH

03307

Reg. Dist. No. 6

1. PLACE OF DEATH:
County: Allegany
City or town: Luke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 Years
Hospital, institution, or street address where death occurred: 225 Cromwell St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Luke, ~~Maryland~~
(If outside city or town limits, write RURAL and give nearest town)
Street No. 225 Cromwell St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Thomas Edward Bradley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	~~Single~~ Widower

6.(b) Name of husband or wife: Anna Bradley
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 10 April 1864

8. AGE: Years: 82 | Months: 0 | Days: 6 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Luray, Loudon, Virginia (Town, county, and state)
10. Usual occupation: Miner
11. Industry or business: Coal Mine
FATHER 12. Name: Samuel Bradley
13. Birthplace: Virginia
MOTHER 14. Maiden name: Not known
15. Birthplace: Not known
16. Informant: Samuel Bradley
Address: 225 Cromwell St, Luke, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 18 April 1946 (month) (day) (year)
Cemetery or crematory: Bloomington Cemetary
Location: Bloomington, Md
18. Funeral director: Ellsworth S. Boal
Address: 111 Church St, Westernport, Md.
19. Apr 17 1946 (Date rec'd by registrar) A. Baxinbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 April 1946 at 2:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-12 1946 to 4-16 1946
and that I last saw h... alive on 4-15 1946

	DURATION
Immediate cause of death: Cerebral hemorrhage	
Due to: fractured skull	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 4-12-46
Where did injury occur? Luke (City or town) Allegany (County) Md. (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: fell down steps Injured at work? no

23. SIGNATURE: P.E. Berry M.D. (M. D. or other)
Address: Piedmont, W.Va. Date signed: 4-16-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
APR 18 1946
BUREAU V.E.

Within corporate limits

Evidence for change of birth date of deceased is shown on FILM No. I 04 MAY 20 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03308

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ronald Marvin Bridges

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 5 1930

8. AGE:

Years	Months	Days	If less than one day
15	11	23	hrs. min.

9. Birthplace: Mt. Savage, Allegany, Md. (Town, county, and state)
10. Usual occupation: School Child
11. Industry or business

FATHER
12. Name: George A. Bridges
13. Birthplace: Mt. Savage, Md.

MOTHER
14. Maiden name: Charlotte Meyers
15. Birthplace: Williamsburg, Md.

16. Informant: Mrs. Elsie Bridges
Address: Mt. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-30-1945 (month) (day) (year)
Cemetery or crematory: Methodist Church
Location: Mt. Savage Md.
18. Funeral director: Grant Bates
Address: Keating, Md.

19. April 30, 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28, 1946, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..., 19..., to ..., 19...
and that I last saw h... alive on ..., 19...

Immediate cause of death	DURATION
Pericarditis with Effusion	3 wks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John A Topper M.D. M. D. or other
Address: Hyndman Pa. Date signed 4-29-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 3 1946
BUREAU V. S.

Outside of City Limits Barrett

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

03309

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town (Rural) Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:
Rt. 2. Cumberland, Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town (Rural) Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. 2
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Alonzo Brown

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Laura Brown

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) December 26, 1869

8. AGE: Years	Months	Days	If less than one day
76	3	28	...hrs. ...min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual occupation Laborer (Retired)

11. Industry or business Tannery

FATHER 12. Name Isaac Brown

13. Birthplace Pa.

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant Raymond Brown

Address Rt. 2, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 26, 1946 (month) (day) (year)

Cemetery or crematory Zion Memorial

Location Cumberland, Md

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. April 26 1946 J. P. Franklin, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24, 1946 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Coronary Thrombosis - Sudden	
Due to (Pronounced Dead)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ...Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clay E. Furnas M. D. or other

Address Cumberland Date signed Apr. 26, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
APR 30 1946
BUREAU V-[redacted]

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

CERTIFICATE OF DEATH

03310

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, institution, or street address where death occurred: 400 Warwick Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 400 Warwick Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Leota Brown

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: John E. Brown

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): March 18, 1888

8. AGE: Years	Months	Days	If less than one day
58	1	2	...hrs. ...min.

9. Birthplace: Spencer, W. Va. (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: Own home

FATHER — 12. Name: Alban B. Vida

FATHER — 13. Birthplace: W. Va.

MOTHER — 14. Maiden name: Un Known

MOTHER — 15. Birthplace

16. Informant: John E. Brown

Address: 400 Warwick Ave., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 23, 1946 (month) (day) (year)

Cemetery or crematory: Spencer Memorial Cemetery, Inc.

Location: Spencer, W. Va.

18. Funeral director: John J. Hofer

Address: Cumberland, Md.

19. April 20, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20, 1946, at 4:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 29, 1945 to April 20, 1946 and that I last saw ... alive on April 20, 1946

	DURATION
Immediate cause of death: Hypertensive Cardiovascular Renal disease	?
Due to: Coronary Artery disease	?
Due to: Myocardial disease	
Other conditions: Arterio Sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: [illegible] Date signed: 4/20/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 23 1946
BUREAU OF

Within corporate limits

DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (39)

CERTIFICATE OF DEATH

03311 4

Reg. Dist. No.

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 5 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WEST VIRGINIA County GRANT

City or town MAYSVILLE

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

BABY BOY COOK (PREMATURE)

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	BABY

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 26, 1946

8. AGE: Years | Months | Days | If less than one day: 5 hrs. 45 min.

9. Birthplace CUMBERLAND, MD.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name BROOK A. COOK

13. Birthplace WEST VIRGINIA

MOTHER 14. Maiden name MARJORIE JUDY

15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. (Burial, cremation, or removal. Which?) Cremation Date thereof April 26, 1946 (month) (day) (year)

Cemetery or crematory Memorial Hosp.

Location Cumberland, Md.

18. Funeral director Same

Address

19. April 26, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 26 1946 at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-26 1946 to 4-26 1946 and that I last saw h. alive on 1946

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. Hodges, M.D.

Address Cumberland, Md. M. D. or other Date signed 4/26/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
APR 30 1946
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03312 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred: 308 Maryland Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport (If outside city or town limits, write RURAL and give nearest town)

Street No.: 308 Maryland Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Lildian Alice DeLauter

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Leroy W. DeLauter

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): 11 June 1888

8. AGE: Years	Months	Days	If less than one day
57	10	9	...hrs. ...min.

9. Birthplace: Westernport, Allegany, Md (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: own home

FATHER — 12. Name: Isaac H. Kooken

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Susan A. Kight

MOTHER — 15. Birthplace: Maryland

16. Informant: Edward DeLauter

Address: 308 Md. Ave, Westernport, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 23 April 1946 (month) (day) (year)

Cemetery or crematory: Philos Cemetary

Location: Westernport, Md

18. Funeral director: Ellsworth S. Boal

Address: 111 Church St., Westernport, Md

19. Apr. 23 19 46 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 20 April 1946, at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9 1946, to April 20 1946 and that I last saw h... alive on April 20 1946

Immediate cause of death	DURATION
Congestive heart failure.	4 mo
Due to Chronic valvular heart disease	6 years
Due to Cause undetermined	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James A. Robertson M.D. M. D. or other

Address: Piedmont W. Va. Date signed: April 23, 1946

RECEIVED
APR 25 1946
BUREAU V.R.

Within corporate limits

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-2)

CERTIFICATE OF DEATH

03313

FILM No. I 04 MAY 15 1946

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 Hrs.

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: W. Va. County: Mineral

City or town: Ridgley

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 11 Barncord St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Louie DeRosa

3.(b) Social Security Number: 217-10-6603

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Antionette DeRosa

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 29, 1879

8. AGE: Years	Months	Days	If less than one day
66 76	10	29	hrs. min.

9. Birthplace: Naples, Italy (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Kelly Springfield Tire Co.

FATHER — 12. Name: Jack DeRosa

FATHER — 13. Birthplace: Italy

MOTHER — 14. Maiden name: Anna Cardelle

MOTHER — 15. Birthplace: Italy

16. Informant: Mrs. Elizabeth Rapillo

Address: 11 Barncord St. Ridgeley, W. Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 1, 1946 (month) (day) (year)

Cemetery or crematory: S.S. Peter & Paul

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. April 30, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 28, 1946, at 10:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 1945, to April 28 1946 and that I last saw h[illegible] alive on April 28 1946

Immediate cause of death	DURATION
Cerebral Coronary Thrombosis	2 days
Due to Acute Broncho Pneumonia	3
Due to Myocardial Disease	3
Congestive Heart Failure	6
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Samuel DeRosa M. D. or other

Address: [illegible] Date signed: 4/29/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 3 1946
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

03314

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 years

Hospital, institution, or street address where death occurred:
112 Howard Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)

Street No. 112 Howard Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William Oren DeVore

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ida B. DeVore

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): November 4, 1878

8. AGE: Years: 67 | Months: 5 | Days: 11 | If less than one day: ...hrs. ...min.

9. Birthplace: Buffalo Mills, Bedford, Penna (Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business: Grocery Store

FATHER — 12. Name: Harmon DeVore

13. Birthplace: Penna

MOTHER — 14. Maiden name: Rosella Malsberry

15. Birthplace: Penna

18. Informant: Mrs Ida B. DeVore

Address: 112 Howard St, Westernport, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 17, 1946 (month) (day) (year)

Cemetery or crematory: Philos Cemetary

Location: Westernport, Md

18. Funeral director: Ellsworth S. Boal

Address: 111 Church St, Westernport, Md

19. Apr 17 1946 (Date rec'd by registrar) A. Gaynn Baker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 April 1946 19... at 4:05 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13 19 46 to April 15 19 46

and that I last saw h... alive on April 14 19 46

	DURATION
Immediate cause of death: Intra Cranial Hemorrhage	3 days
Due to:	
Due to:	
Other conditions: Diabetes Mellitus	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Harman Reeves M. D.

Address: Westernport Md M. D. or other

Date signed: 4-16-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 18 1946
BUREAU V. R.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

03315

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred: Memorial Hospital.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 325 Beall St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles H Diehl

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Rose A. Winterstein

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 9 1879

8. AGE:

Years	Months	Days	If less than one day
66	5	17	hrs. ..... min.

9. Birthplace Bedford Co. Pa.
(Town, county, and state)

10. Usual occupation Grocer.

11. Industry or business Own Business

FATHER 12. Name Solomon Diehl

13. Birthplace Penna

MOTHER 14. Maiden name Melinda Whetstone

15. Birthplace Penna

16. Informant Mrs. Mildred Diehl

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 24 1946 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetary

Location Cumberland, Md.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Md.

19. April 24, 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April - 21 1946, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4 1943, to April 21 1946 and that I last saw h... alive on April 18 1946.

	DURATION
Immediate cause of death: congestive heart failure	8 weeks
Due to: chronic myocarditis	3 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. Wilkins M.D.
M. D. or other

Address Lonaconing Md. Date signed 4-22-46

RECEIVED
APR 30 1946
BUREAU V R

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

03316

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs

Hospital, Institution, or street address where death occurred: Beechwood St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Beechwood
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Thomas Earl Dolan

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband~~ or wife: Rachael Duckworth

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Nov. 8, 1866

8. AGE:

Years	Months	Days	If less than one day
79	5	8	____ hrs. ____ min.

9. Birthplace: Jacksonville, Texas
(Town, county, and state)

10. Usual occupation: Coal Miner - Retired

11. Industry or business: Koontz Mine

FATHER
12. Name: Reuben Dolan
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: James Dolan
Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 19, 1946 (month) (day) (year)

Cemetery or crematory: Old Coney Cemetery

Location: Lonaconing, Md.

18. Funeral director: Jos. Eichhorn

Address: Lonaconing, Md.

19. April 19 1946 (Date rec'd by registrar) D. E. Oon-ffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16th 1946, at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15th 1946, to April 16 1946, and that I last saw h[illegible] alive on April 15 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: [illegible] Date signed: April 17, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
APR 23 1946
BUREAU

Within corporate limits? Yes

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-6)

CERTIFICATE OF DEATH

★ 03317

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 85 years

Hospital, institution, or street address where death occurred: 313 Central Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 313 Central Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Annie W. Edwards

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Negro	Married

6.(b) Name of husband or wife: Marcellus Edwards

6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): January 8, 1861

8. AGE: Years	Months	Days	If less than one day
85	3	9	hrs. min.

9. Birthplace: Cumberland, Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER 12. Name: Nicholas Francis

FATHER 13. Birthplace: Md

MOTHER 14. Maiden name: Miranda Gibson

MOTHER 15. Birthplace: Hancock, Md.

16. Informant: Marcellus Edwards

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 20, 1946 (month) (day) (year)

Cemetery or crematory: Sumner Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. April 20 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17 1946 at 11:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1946 to April 17 1946 and that I last saw h... alive on April 16 1946

Immediate cause of death	DURATION
Uraemic Coma	2 days
Due to (Chronic Glomerulo-Nephritis)	2 Mos
Due to (Chronic Heart Disease)	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Thos. M. Lowe M. D. or other

Address: Cumberland, Md Date signed 4-21-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
APR 23 1946
BUREAU V S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

03318

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Pennsylvania County: Bedford
City or town: Near Centreville, rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Bedford Valley, Rt. #3
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME: Thomas Wendel Elliott

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 27, 1925

8. AGE: Years	Months	Days	If less than one day
21	2	10	hrs. min.

9. Birthplace: Bedford Valley, Pennsylvania
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Walter Elliott
13. Birthplace: Bedford Valley, Pa.

MOTHER
14. Maiden name: Marie Cessna
15. Birthplace: Centreville, Pa.

16. Informant: Mr. Walter Elliott
Address: R.D.#3 Bedford Penna.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 9, 1946 (month) (day) (year)
Cemetery or crematory: Bethel Cemetery
Location: Bedford Road, Pa.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. April 9 1946 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6 1946 at 5:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 1946 to April 6 1946 and that I last saw h... alive on April 6 1946

	DURATION
Immediate cause of death: Intracerebral hemorrhage	5 days
Intracerebral hemorrhage	
Due to: kick by horse	
Due to:	
Other conditions: ruptured spleen	5 days

(Include pregnancy within 3 months of death)

Major findings of operations: ruptured spleen, incised intracranial lesion Date of op. 4-2-46
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, ~~suicide, or homicide~~: kick by horse Date of 4-2-46
Where did injury occur? Bedford road rt 3 Pa (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): farm
Means of injury: kick by horse Injured at work? yes

23. SIGNATURE: L. Wrings M.D. M. D. or other
Address: 59 Greene St. Date signed: 4-7-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 2-15-15M

RECEIVED
APR 16 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186a

03319

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany

City or town Moscow
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Moscow
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Fairgrieve

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Amanda Fairgrieve

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 24 May 1858

8. AGE: Years	Months	Days	If less than one day
87	11	0	hrs. min.

9. Birthplace Scotland
(Town, county, and state)

10. Usual occupation Miner

11. Industry or business Coal mine

FATHER 12. Name John Fairgrieve

13. Birthplace Scotland

MOTHER 14. Maiden name Elizabeth Peacock

15. Birthplace Scotland

16. Informant Mrs Edward Taylor

Address Moscow, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 27 April 1946 (month) (day) (year)

Cemetery or crematory Laurel Hill Cemetary

Location Moscow, Maryland

18. Funeral director Ellsworth S. Boal

Address 111 Church St, Westernport, Md

19. April 27 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 April 19 46 at 8:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24 19 46 to Apr. 24 19 46

and that I last saw h alive on April 24 19 46

Immediate cause of death Fracture of hip

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry W. Hodgson M.D.

M. D. or other

Address Lonaconing Md Date signed April 27 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
APR 29 1946
BUREAU V.S.

Outside of City Limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

03320

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr

Hospital, Institution, or street address where death occurred: Bedford Rd, R.F.D. #3

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Barton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Julia Kelly Footen

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Peter Footen

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 11, 1876

8. AGE: Years	Months	Days	If less than one day
69	8	8	..... hrs. ..... min.

9. Birthplace: Pekin - Allegany - Md.

(Town, county, and state)

10. Usual occupation: Farmer - housewife

11. Industry or business

FATHER 12. Name: Edward Kelly

FATHER 13. Birthplace: Ireland

MOTHER 14. Maiden name: Pauline Jessie

MOTHER 15. Birthplace: unknown

16. Informant: Paul Footen

Address: Barton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 22/46 (month) (day) (year)

Cemetery or crematory: St. Gabriels Cem.

Location: Barton Md.

18. Funeral director: Ellsworth-S. Boal

Address: Westernport Md

19. April 20, 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1946 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13 1946 to April 19 1946 and that I last saw h.. alive on April 13 1946

Immediate cause of death	DURATION
Arteriosclerosis	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. E. Johnson Jr. M.D. M. D. or other

Address: Cumberland Md Date signed: 4-19-46

RECEIVED
APR 23 1946
BUREAU V. S.

Within corporate limits for addition of sex is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

FILM No. I 0 4 MAY 10 1946

CERTIFICATE OF DEATH

03321 4

Reg. Diat. No.

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Allegany Hospital, Cumberland, Md.

How long in hospital or Institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Pennsylvania County Bedford

City or town Artemas (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

~~G[illegible]~~, Mr. Joseph Gaspari

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
~~63~~ Male	White	Married

6.(b) Name of husband or wife Mrs. Mary (Croston) ~~Gaspari~~

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) August 8th, 1882

8. AGE: Years	Months	Days	If less than one day
63	8	18	....hrs. ....min.

9. Birthplace Italy (Town, county, and state)

10. Usual occupation Farming

11. Industry or business Own farm

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden name

15. Birthplace

16. Informant Mary Gaspari

Address Rt. #1, Artemas, Penna

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29, 1946. (month) (day) (year)

Cemetery or crematory Fairview Christian Cem

Location near artemas, Penna

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. April 29, 1946 (Date rec'd by registrar) J. P. Hankin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/26 19 46, at 10:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-6 19 46 to 4-26 19 46

and that I last saw h[illegible] alive on 4-25 19 46

Immediate cause of death	DURATION
Carcinoma of stomach	Months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Carcinoma of stomach with metastasis Date of op. 4-17-46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James J. Johnson M.D. M. D. or other

Address Cumberland, Md. Date signed 4-29-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15-1 9-45-15M

RECEIVED
MAY 3 1946
BUREAU V P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03322

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Vale Summit
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Vale Summit
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Chester Irvin Goodwin

3.(b) Social Security Number 213-05-7140

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret Agnes
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): August 8, 1888

8. AGE: Years 57 | Months 8 | Days 6 | If less than one day ... hrs. ... min.

9. Birthplace: Framingham, Middlesex, Mass.
(Town, county, and state)

10. Usual occupation: Invalid

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: George Goodwin
Address: Vale Summit Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April '17 1946 (month) (day) (year)
Cemetery or crematory: St. Michael's Cemetery
Location: Frostburg Md.

18. Funeral director: J. D. Dist
Address: Frostburg Md.

19. 4-17 1946 (Date rec'd by registrar) Mrs. Hardy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17 1946, at 8:00 P.M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from April 11 1946, to April 17 1946
and that I last saw him alive on April 11 1946

Immediate cause of death	DURATION
Paralysis Agitans	Several years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. M. Lane M.D.
M. D. or other
Address: Frostburg Md. Date signed: 4-16-46

RECEIVED
APR 20 1966
BUREAU W

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

03323

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 8 hours and 25 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 19 South St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Jane Gordon ~~Twin~~ 1
Baby girl Gordon

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) April 2, 1946 at 4:45 A.M.

8. AGE: Years	Months	Days	If less than one day
			8 hrs. 25 min.

9. Birthplace: Cumberland, Allegany Co., Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER
12. Name: Lawrence Andrew Gordon
13. Birthplace: Mt. Vernon, Maine

MOTHER
14. Maiden name: Teresa Mackert
Cumberland, Maryland

16. Informant: Lawrence A. Gordon
Address: 19 Sooth St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 3 1946 (month) (day) (year)
Cemetery or crematory: Sts. Peter & Paul Cemetary
Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. April 3, 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2 1946, at 1:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 1946 to Apr 2 1946
and that I last saw h[illegible] alive on Apr 2 1946.

Immediate cause of death	DURATION
Premature birth	Hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. N. Trevaskis M.D.
M. D. or other
Address: Cumberland, Md. Date signed: 4/3/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
APR 9 1946
BUREAU V.S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

03324

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? Six hours and fifty min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 19 South St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Mary Gordon
Baby girl Gordon - Twin #2

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 2, 1946 at 5:00 A.M.

8. AGE: Years | Months | Days | If less than one day: 6 hrs. 50 min.

9. Birthplace: Cumberland, Allegany Co., Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER 12. Name: Lawrence Andrew Gordon
FATHER 13. Birthplace: Mt. Vernon, Maine

MOTHER 14. Maiden name: Teresa Mackert
MOTHER 15. Birthplace: Cumberland, Maryland

16. Informant: Lawrence A. Gordon
Address: 19 South St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 3 1946 (month) (day) (year)
Cemetery or crematory: Sts. Peter & Paul Cemetary
Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. April 3, 1946 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2, 1946, at 11:50A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2, 1946, to April 2, 1946, and that I last saw her alive on April 2, 1946.

Immediate cause of death	DURATION
Premature birth	Mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. V. Tureski M.D.
M. D. or other
Address: Cumberland, Md. Date signed: 4/3/46

RECEIVED
APR 9 1946
BUREAU V. S.

Within corporate limits

DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (KO-3)

03325

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address (if not in hospital) where death occurred: Memorial Hospital

How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 233 CUMBERLAND ST.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME ~~Douglas~~ Warren ~~BABY BOY~~ GRAHAM

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 27, 1946

8. AGE: Years | Months | Days 1 | If less than one day hrs. min.

9. Birthplace MARYLAND, Cumberland, Alleg. Co.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name HERBERT GRAHAM

13. Birthplace NEW YORK, Brooklyn

MOTHER 14. Maiden name RUTH SCHMIDT

15. Birthplace NEW Jersey, Jersey City

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof April 28, 1946 (month) (day) (year)

Cemetery or crematory Memorial Hosp.

Location Cumberland, Md.

18. Funeral director Same

Address

19. April 28, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APR. 28, 1946 at 1:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APR. 27, 1946 to APR. 28, 1946 and that I last saw him alive on APR. 28, 1946

	DURATION
Immediate cause of death: Acute Cranial Hemorrhage	
Due to: Premature Birth	
Due to: Edema of Lungs	
Other conditions: Cyanosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M.R. Hodges M. D. or other

Address Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
MAY 3 1946
BUREAU V.R.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-9)

CERTIFICATE OF DEATH

03326

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital, Cumberland, Maryland

How long in hospital or institution? 41 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: West Virginia County: Mineral

City or town: Ridgeley (If outside city or town limits, write RURAL and give nearest town)

Street No. 7 Lee St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Hager, Mrs. Mabel

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John W Hager 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 26 1903

8. AGE: Years 42 Months 9 Days 4 If less than one day hrs. min.

9. Birthplace: Thomas W. Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: George W Lease

13. Birthplace: W. Va

MOTHER 14. Maiden name: Harriet Frantham

15. Birthplace: W Va

18. Informant: John W Hager

Address: Ridgley W. Va.

17. Mineral (Burial, cremation, or removal. Which?) Date thereof May 3 46 (month) (day) (year)

Cemetery or crematory: Hillcrest Mem

Location: Cumberland

18. Funeral director: Louis Stein Sons

Address: Cumberland

19. May 7 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/30 1946 at 5:49 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4 '45 to April 30 1946 and that I last saw h[illegible]r alive on April 30 1946

	DURATION
Immediate cause of death: Coronary thrombosis	5 yrs.
Due to: Arteriosclerotic heart disease, Mitral	
Due to: and tricuspidal insufficiency	
Other conditions: Latent syphilis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Elizabeth Gump M.D. M. D. or other

Address: Same Date signed 5/7/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
MAY 3 1946
BUREAU V M.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03327

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Allegany Hospital, Cumberland, Maryland
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)
Street No. 409 Decatur St. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Hammersmith, Mrs. Ida

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Mr. John A. Hammersmith
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 21, 1887

8. AGE: Years	Months	Days	If less than one day
59	1	16	..... hrs. ..... min.

9. Birthplace: Rohrersville, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Jesse J. Price
13. Birthplace: Md

MOTHER
14. Maiden name: Mary E. Hines
15. Birthplace: Md

16. Informant: John Hammersmith
Address: 409 Decatur St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 9, 1946 (month) (day) (year)
Cemetery or crematory: St. Peters & Pauls
Location: Fayette St. Cumberland, Md
18. Funeral director: Louis Stein Inc
Address: Cumberland, Md

19. April 8, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/7 1946, at 2:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-5-46 1946, to 4-7-46 1946 and that I last saw h.. alive on 4-6-46 1946

Immediate cause of death	DURATION
(a) Carcinoma Rectum	18 mo.
Due to	
Due to	
Other conditions Nephritis, Diabetes	?

(Include pregnancy within 3 months of death)
Major findings of operation: Carcinoma Rectum advanced Date of op. 4-6-46
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M.D. or other
Address ..... Date signed 4-8-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
APR 16 1946
BUREAU U.S.

DR. W. F. WILLIAMS
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (26)

03328

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 715 VIRGINIA AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
MRS. MARGARET HARVEY

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	DIVORCED

6.(b) Name of husband or wife Unknown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) SEPTEMBER 11, 1888

8. AGE: Years	Months	Days	If less than one day
57	6	24	..... hrs. ..... min.

9. Birthplace MARYLAND
(Town, county, and state)
10. Usual occupation HOUSEWORK
11. Industry or business

FATHER
12. Name GUS HARVEY
13. Birthplace MARYLAND

MOTHER
14. Maiden name ELLEN OSBURN
15. Birthplace SCOTLAND

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 7, 1946 (month) (day) (year)
Cemetery or crematory Hillcrest Burial Park
Location Cumberland, Maryland

18. Funeral director William H. Kight
Address Cumberland, Maryland

19. April 6 19 46 Joseph A. Dashiell M.S. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 5, 1946 9:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APRIL 3, 1946, to APR. 5, 1946 and that I last saw h... alive on APR. 5, 1946

Immediate cause of death	DURATION
Due to A very few minutes after intubation	
Due to Anaesthia (Peritoneal Sodium) She died	
Other conditions Was to be operated for a very serious	
(Include pregnancy within 3 months of death)	
Major findings of operations Cholecystitis & stones	
Autopsy results	

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Wm. F. Williams M. D. or other
Address Cumberland, Md. Date signed 4-5-46

RECEIVED
APR 9 1946
BUREAU V R

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

03329

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Luke (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred: 318 Pratt St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Luke (If outside city or town limits, write RURAL and give nearest town)

Street No. 318 Pratt St (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Thomas Jefferson Haywood

3. (b) Social Security Number: 109-01-4652

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Amanda B. Haywood

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): 13 April 1875

8. AGE:

Years	Months	Days	If less than one day
71	0	13	..... hrs. ..... min.

9. Birthplace: Foster, Staffordshire, England (Town, county, and state)

10. Usual occupation: Superintendant, Order Dept.

11. Industry or business: Pulp and Paper Mill

FATHER

12. Name: Samuel Haywood

13. Birthplace: England

MOTHER

14. Maiden name: Mary Wood

15. Birthplace: England

16. Informant: Gerald Haywood

Address: Md. Ave, Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 28 April 1946 (month) (day) (year)

Cemetery or crematory: Philos Cemetary

Location: Westernport, Maryland

18. Funeral director: Ellsworth S. Boal

Address: 111 Church St, Westernport, Md

19. Apr. 28 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 April 1946, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1946 to April 26 1946 and that I last saw him alive on April 26 1946

Immediate cause of death	DURATION
Carcinoma of left breast	8 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James H. Wharton Jr. M.D. (M.D. or other)

Address: Richmond W. Va. Date signed: April 28, 1946

RECEIVED
APR 29 1946
BUREAU V-E

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

03330

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 66 yrs

Hospital, Institution, or street address where death occurred:
Rear of 441 Walnut St.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 111 Lennox Place
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Espy Hext

3.(b) Social Security Number 218-24-8294

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 2 1880

8. AGE:

Years	Months	Days	If less than one day
66	—	—	....hrs. ....min.

9. Birthplace Cumberland, Allegany, Maryland
(Town, county, and state)

10. Usual occupation Butcher

11. Industry or business —

FATHER 12. Name Will Hext

13. Birthplace England

MOTHER 14. Maiden name Ellen Gorley

15. Birthplace Penna.

16. Informant Mrs. Mary A. Ritter

Address 111 Lennox Place. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 4 1946 (month) (day) (year)

Cemetery or crematory St. Lukes Cemetary

Location Cumberland, Md.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Md.

19 April 3, 19 46 J. P. Franklin, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2nd., 19 46, at 6.15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceasad from ....19...., to ....19....

and that I last saw h....alive on ....19....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ---

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thomas H. Bowen, M.D.
M. D. or other

Address Cumberland, Maryland Date signed 4-2-46

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

RECEIVED
APR 9 1946
BUREAU U.S.

Outside of City Limits

Mr. Elinson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

03331

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: R.D. #2 Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs.
Hospital, institution, or street address where death occurred: R. D. #2 Williams Rd. Cumberland,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: R. D. #2 Williams Rd. Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Williams Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: THOMAS HAROLD HIGHLAND

3. (b) Social Security Number: 273-10-0190

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth Strieby
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 13, 1905

8. AGE: Years	Months	Days	If less than one day
41	2	24	hrs. min.

9. Birthplace: Marietta, Ohio (Town, county, and state)
10. Usual occupation: Pharmacist
11. Industry or business: Fords Drug Store Manager

FATHER
12. Name: Thomas P. Highland
13. Birthplace: Ohio

MOTHER
14. Maiden name: Flora Schultheis
15. Birthplace: Ohio

16. Informant: Mrs. Elizabeth Highland
Address: R. D. #2 Williams Rd. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 10, 46 (month) (day) (year)
Cemetery or crematory: Levels Cem.
Location: Levels, W. Va.
18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. April 10, 1946 J.P. Franklin, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6, 1946, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 1946 to April 6 1946 and that I last saw h... alive on April 6 1946

Immediate cause of death	DURATION
Coronary Occlusion	1 hour
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: A. C. Elinson Jr. M. D. or other
Address: 126 Young Cumberland Md. Date signed: 4/8/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 16 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64)

CERTIFICATE OF DEATH

03332 6

Reg. Dist. No.

1. PLACE OF DEATH:
County: Allegany
City or town: Luke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Luke
(If outside city or town limits, write RURAL and give nearest town)
Street No. 218 Cromwell St
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME: James William Hill

3.(b) Social Security Number: 218-16-3984

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 31, 1924

8. AGE:

Years	Months	Days	If less than one day
21	3	3	hrs. min.

9. Birthplace: Luke, Maryland
(Town, county, and state)

10. Usual occupation: Coating Mill Employee

11. Industry or business: Pulp and Paper Mill

FATHER
12. Name: William D. Hill
13. Birthplace: Providence, Md

MOTHER
14. Maiden name: Margaret L. Jack
15. Birthplace: Luke, Md

16. Informant: Margaret L. Jack
Address: 218 Cromwell, Luke

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7 April 1946 (month) (day) (year)
Cemetery or crematory: Philos Cemetary
Location: Westernport Md

18. Funeral director: Ellsworth S. Boal
Address: 111 Church St, Westernport, Md

19. April 6 1946 (Date rec'd by registrar) [signature illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 4th, 1946 at about 10.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Suicide by gunshot (16 gauge)	killed instantly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.
Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: suicide Date of: 4-4-46
Where did injury occur? Luke (City or town), Allegany (County), Maryland (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: gun shot Injured at work? no

23. SIGNATURE: Bruce H. Brown M.D.
M. D. or other
Address: Cumberland, Maryland. Date signed: 4-5-46

Deputy Medical Examiner - Allegany Co.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
APR 8 1946
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03333

Reg. Diat. No. 10

1. PLACE OF DEATH:

County: Allegany

City or town: Mt Savage

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred: Rural

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Mt Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Henritta Hite

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 13 1869

8. AGE: Years: 76 Months: 6 Days: 23 If less than one day: ..... hrs. ..... min.

9. Birthplace: Bedford Valley Bedford Co Pa (Town, county, and state)

10. Usual occupation: Home Duty

11. Industry or business: "

MOTHER FATHER

12. Name: Albert Hite

13. Birthplace: Bedford Valley Pa

MOTHER

14. Maiden name: Amanda Deffibaugh

15. Birthplace: Bedford Valley Pa

16. Informant: Mrs Helen Cessna

Address: Mt Savage Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/8/46 (month) (day) (year)

Cemetery or crematory: Bethel Cemetery

Location: Centerville Pa

18. Funeral director: William H. Knight

Address: Cumberland Md

19. 4-7-46 (Date rec'd by registrar) Vernon McDermott Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6 1946 at 10:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1945 to April 5 1946 and that I last saw h... alive on April 5 1946

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions: Bronchial Asthma, Chronic Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: William E. Mosley, M. D. or other

Address: Mt Savage Md Date signed 4-6-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
APR 24 1946
BUREAU V.S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

03335

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 DAYS

Hospital, institution, or street address where death occurred: MEMORIAL Hospital

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State W. VA. County GRANT

City or town PETERSBURG (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MRS. AGNES HODGES

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife CHARLEY R. HODGES

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) OCT. 22, 1878

8. AGE: Years	Months	Days	If less than one day
67	5	15	..... hrs. ..... min.

9. Birthplace PETERSBURG, W. VA. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

MOTHER FATHER

12. Name WILLIAM MALCOLM

13. Birthplace SCOTLAND

14. Maiden name JEAN KELSO SCOTT

15. Birthplace SCOTLAND

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 10, 1946 (month) (day) (year)

Cemetery or crematory Queens Point Cem.

Location Keyser, W. Va.

18. Funeral director Markwood Funeral Director

Address Keyser, W. Va.

19. April 9 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 7 1946, at 1:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25, 1946, to April 7, 1946 and that I last saw her alive on April 7, 1946

Immediate cause of death Carcinoma of Colon DURATION

Due to Carcinoma of Liver

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. F. Hawkins M. D. or other

Address Cumberland Md. Date signed 4/8/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
APR 16 1946
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

03334

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 68

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 48 Broadway

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Emma Martha Christine Doling

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 20 1881

8. AGE: Years: 65 Months: 1 Days: 20 If less than one day: hrs. min.

9. Birthplace: Lonaconing, Allegany, Md. (Town, county, and state)

10. Usual occupation: Farmer Wife

11. Industry or business:

FATHER — 12. Name: Otto Doling

13. Birthplace: Lonaconing, Md.

MOTHER — 14. Maiden name: Emma E. Hastings

15. Birthplace: Frostburg, Md.

16. Informant: Otto Doling Jr. Address: 48 Broadway Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-22-1946 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: Joseph Roe

Address: Frostburg, Md.

19. 4-22 1946 (Date rec'd by registrar) Miss Nancy A. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1946, at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/15 1942 to 4/19 1946 and that I last saw her alive on March 11 1946

Immediate cause of death	DURATION
Coronary attack	
Due to: Hypertensive Arterio-sclerotic heart disease	2 yrs
Due to:	
Other conditions: Diabetes mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Hilda Jones Waldron M.D. M. D. or other

Address: Frostburg Date signed: 4/21/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
APR 25 1946
BUREAU V &

Within corporate limits

Ro 20

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

03337

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 years

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 3 weeks 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 487 Eastern Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ethel May Imes

3.(b) Social Security Number 214-05-4200

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Marshall E. Imes

6.(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) July 20, 1901

8. AGE:

Years	Months	Days	If less than one day
44	8	23	..... hrs. ..... min.

9. Birthplace Cheneysville, Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER
12. Name Jacob H. Adams
13. Birthplace Cheneysville, Pa.

MOTHER
14. Maiden name Nancy F. Smith
15. Birthplace Cheneysville, Pa.

16. Informant Marshall Imes

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 16, 1946 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. April 15, 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13/46 19..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/23/46 19..... to 4/13/46 19.....

and that I last saw h.. alive on 4/13/46 19.....

	DURATION
Immediate cause of death Cerebral Hemorrhage -	days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Cystectomy - Incised uterus Date of op. 3/23/46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John K Rozzell M D
M. D. or other

Address Cumberland (Md) Date signed 4/13/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
APR 23 1946
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

03336

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:
County: Allegany
City or town: Barton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 62 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Barton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Lillie Mason Inskeep

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 1, 1883

8. AGE: Years	Months	Days	If less than one day
62	4	1	..... hrs. ..... min.

9. Birthplace: Barton-Allegany-Md (Town, county, and state)
10. Usual occupation: School Teacher
11. Industry or business

FATHER
12. Name: Charles Inskeep
13. Birthplace: Barton, Md

MOTHER
14. Maiden name: Marie Elizabeth Kight
15. Birthplace: Barton, Md

16. Informant: Mrs Elizabeth Inskeep
Address: Barton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 5, 1946 (month) (day) (year)
Cemetery or crematory: Philos Cemetary
Location: Westernport Md
18. Funeral director: Ellsworth S. Boal
Address: 111 Church St, Westernport, Md
19. April 5 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 April 19 46 at 1:00a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from apl 2 19 46, to apl 2 19 46 and that I last saw h dead alive on 4/3/46 19

Immediate cause of death	DURATION
acute Myocarditis	between onset and death
Due to Chronic Heart disease	Long time
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Westernport Md Date signed: 4/4/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 6 1945
BUREAU V-8

Within corporate limits

DR. TOLSON

03338

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 8 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W.VA. County HAMPSHIRE
City or town ROMNEY, W.VA.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JOSEPH T. KIDNER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife GEORGIA LEWIS KIDNER
6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) FEB. 3. 188?

8. AGE: Years	Months	Days	If less than one day
64	2	22	hrs. min.

9. Birthplace W.VA. (Town, county, and state)
10. Usual occupation PROPRIETOR OF BLACKSMITH SHOP
11. Industry or business

FATHER
12. Name JAMES KIDNER
13. Birthplace W.VA.

MOTHER
14. Maiden name SARAH CARDER
15. Birthplace W.VA.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 27, 1946 (month) (day) (year)
Cemetery or crematory Thorne Cemetery
Location Romney W.Va.
18. Funeral director W.F. Metz
Address Augusta W.Va.

19. April 25, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 25 1946 at 7:58 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-17- 1946 to 4-25- 1946
and that I last saw him alive on 4-24- 1946

Immediate cause of death Carcinoma Prostate — DURATION ?
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operation Cystostomy Date of op. 4-22-46
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Howard D. Nelson M.D. M. D. or other
Address Cumberland, Md. Date signed 4-25-46.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
APR 30 1946
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03339

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 88 Bowery
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Elmer Lawson Kight

3.(b) Social Security Number: 214-01-3733

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Margret Kight
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): May 17-1882

8. AGE: Years	Months	Days	If less than one day
63	10	26	hrs. min.

9. Birthplace: Baston Alleg. Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Bellistic plant
FATHER 12. Name: Charles Kight
13. Birthplace: Baston Md.
MOTHER 14. Maiden name: Catherine Patterson
15. Birthplace: Baston Md.
16. Informant: Mrs Elmer Kight
Address: Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 15-1946 (month) (day) (year)
Cemetery or ~~crematory~~: Allegany
Location: Frostburg
18. Funeral director: J. J. Hurst
Address: Frostburg, Md
19. 4-15 (Date rec'd by registrar) 1946 Mrs. Harvey A. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12 1946, at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 1945, to April 12 1946
and that I last saw him alive on April 10 1946

Immediate cause of death	DURATION
Uremia d.	9 mo
Due to Brain	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: Chronic Prostatitis Date of op. July 1945
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. M. Lane M.D.
M. D. or other
Address: Frostburg Md. Date signed April 13 1946

RECEIVED
APR 17 1946
BUREAU V

Within corporate limits

Evidence for change of age of deceased & age of wife & birth date of deceased is shown.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

DR W. WILLIAMS

FILM No. I 01 MAY - 6 1946

CERTIFICATE OF DEATH

03340

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY CO.

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 HOURS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 8 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD. County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 611 PIEDMONT AVE.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MR GEORGE KIRWAN (E) — GEORGE ELMER KIRWAN

3.(b) Social Security Number 705-03-9098

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife ETHEL ~~CRAMMER~~ Cramer

6.(c) If alive, give age 59 60 years

7. Birth date of deceased (mo., day, yr.) MARCH 18 ~~18-91~~ 1886

8. AGE: Years	Months	Days	If less than one day
~~55~~ 60	0	19	hrs. min.

9. Birthplace BALTIMORE Md.
(Town, county, and state)

10. Usual occupation CLAIM AGENT

11. Industry or business B + O RY

FATHER 12. Name GEORGE KIRWAN

13. Birthplace MD

MOTHER 14. Maiden name STELLA GIBSON

15. Birthplace MD.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND MD

17. Burial + Removal (Burial, cremation, or removal. Which?) Date thereof Apr. 8 46 (month) (day) (year)

Cemetery or crematory Woodlawn Cem.

Location Baltimore Md.

18. Funeral director Louis Stein Inc

Address Cumberland

19 April 8, 19 46 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 7 19 46 at 10:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 30 19 46 to April 7 19 46

and that I last saw h~~im~~ alive on April 7 19 46

Immediate cause of death	DURATION
Myocardial Failure	
Due to Coronary Thrombosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. H. Williams M.D. M. D. or other

Address Med. Bldg. Cumb. Md. Date signed 4/8/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
APR 16 1946
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md.)

CERTIFICATE OF DEATH

03341 6
Reg. Dist. No.

1. PLACE OF DEATH:
County: Allegheny
City or town: McCoole, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? two years
Hospital, institution, or street address where death occurred:
Residence, McCoole, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: West Va. County: Taylor
City or town: Grafton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 817 St. John St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Laura Emma Kitzmiller

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Feminine	White	Widow

6.(b) Name of husband or wife: Lewis Kitzmiller
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 17, 1866

8. AGE: Years	Months	Days	If less than one day
79	3	20	5 hrs. 40 min.

9. Birthplace: Nesr Jane Lew, Gilmer Co., W. Va. (Town, county, and state)
10. Usual occupation: Housewife and flowerculture
11. Industry or business: Housewife
FATHER 12. Name: Nathaniel Hefner
13. Birthplace: West Va.
MOTHER 14. Maiden name: Victoria Moore
15. Birthplace: West Va.
16. Informant: Mrs. J. L. Shay
Address: McCoole, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 9 1946 (month) (day) (year)
Cemetery or crematory: Bluemont Cemetery
Location: Grafton, W. Va.
18. Funeral director: E. Haworth (Mrs.)
Address: Westernport Md.
19. April 7 1946 (Date rec'd by registrar) C. Grafenbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-7 1946, at 6.40 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14 1946 to 4-7 1946 and that I last saw her alive on 4-6 1946
Immediate cause of death: Pulmonary Oedema — acute — DURATION: 2 weeks
Due to: myocardial sclerosis chronic
Due to: arteriosclerosis chronic
Other conditions: apoplexy hemiplegia left (1943) — 3 years
(Include pregnancy within 3 months of death)
Major findings of operations: none — Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: none — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: J C Giffin M.D. (M. D. or other)
Address: Keyser W Va. Date signed 4-7-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 9 1946
BUREAU V S

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (162-t)

CERTIFICATE OF DEATH

03342 4
Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany

City or town Rural Cumberland, rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, Institution, or street address where death occurred:
Rt. 2, Cumberland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Near Cumberland, rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. 2
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lutishia Knippenberg

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Henry Knippenberg

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 16, 1854

8. AGE:

Years	Months	Days	If less than one day
91	4	26	hrs. min.

9. Birthplace Patterson Creek, Hampshire, W. Va.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home

FATHER
12. Name Andrew Togdson
13. Birthplace Unknown

MOTHER
14. Maiden name Anne Sichlighter
15. Birthplace Unknown

16. Informant Geo Knippenberg
Address R.F.D. Route 2 Cumb. Md.

17. Burial Date thereof Apr 15, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt Herman

Location Near Cumberland

18. Funeral director John J. Hafer

Address Cumberland, Md

19. April 15, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12th., 1946 at 8.30A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Senility	
(age 91)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ---

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Pierce H. Brown M.D.
M. D. or other

Address Cumberland, Maryland Date signed 4-12-46

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
APR 23 1946
BUREAU V &

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

03343

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
79 Greene St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 79 Greene St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lucy Elizabeth Kraft

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 29, 1871

8. AGE: Years	Months	Days	If less than one day
74	5	11	..... hrs. ..... min.

9. Birthplace: Cumberland, Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER — 12. Name: Andrew Kraft

FATHER — 13. Birthplace: Wurtenburg, Germany

MOTHER — 14. Maiden name: Sarah Guthman

MOTHER — 15. Birthplace: Bedford Valley, Penna.

16. Informant: Miss. Anna Kraft

Address: 79 Greene St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 12, 1946 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. April 12, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 10, 1946, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-23-1940 to 4-10-1946 and that I last saw h alive on Jan. 20 1946

Immediate cause of death	DURATION
Chronic Myocardial Degeneration ?	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Md. Date signed: 4-11-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS/A15 9.45-15M

RECEIVED
APR 16 1946
BUREAU V. R.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

03344

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 76 yrs

Hospital, institution, or street address where death occurred:

951 Bedford St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 951 Bedford St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Frederick Leasure

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Mary E Dawson

6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) Nov 30 1869

8. AGE:

Years	Months	Days	If less than one day
76	4	10	...hrs. ...min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Conductor Ry

11. Industry or business Retired 1933.

MOTHER FATHER

12. Name John Thomas Leasure

13. Birthplace Md

14. Maiden name Catherine Bell

15. Birthplace Md.

16. Informant Miss Elena Leasure

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 13 46 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland

18. Funeral director Louis Stein Sons.

Address Cumberland

19. April 12, 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1946, at 10 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 13 1946 to April 10 1946 and that I last saw h[illegible] alive on April 9 1946

Immediate cause of death	DURATION
Cardio Renal Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. Bailey Hunter M.D. M. D. or other

Address Cumberland Md. Date signed 4/11/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

RECEIVED
APR 16 1946
BUREAU V.M.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

03345

CERTIFICATE OF DEATH [redacted]

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 9 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town WESTERNPORT, MD.
(If outside city or town limits, write RURAL and give nearest town)

Street No. BOX 218
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
ALONZO DAVID LOUGH

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 9, 1945

8. AGE: Years [redacted] Months 10 Days 15 If less than one day hrs. min.

9. Birthplace MARYLAND (Town, county, and state) Allg.

10. Usual occupation CHILD

11. Industry or business

FATHER 12. Name WALTER LOUGH

13. Birthplace WEST VIRGINIA

MOTHER 14. Maiden name ROSIE L. BAKER

15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 23 1946 (month) (day) (year)

Cemetery or crematory Lincoln Cem.

Location Cross, W. Va.

18. Funeral director Ellsworth S. Bird

Address Westernport Md

19. April 22 1946 J. B. Franklin, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 22, 1946 at 8:05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APRIL 13, 1946 to APR. 22, 1946 and that I last saw him alive on APR. 22, 1946

	DURATION
Immediate cause of death Pneumonitis	10 days
Due to Accidental fall—Child fell out of high chair	
Due to 3 Fractured Ribs	3 wks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of

Where did injury occur? Piedmont, R.F.D. (City or town) West Virginia (County) (State)

Injured at home, farm, industry, public place (where?) At home

Means of injury Accidental fall. Injured at work?

23. SIGNATURE P. T. Owen M.D.
M. D. or other

Address Cumberland Md Date signed Apr 22-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

RECEIVED
APR 30 1946
BUREAU U.S.

Within corporate limits

DR. W.F.WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75-E)

CERTIFICATE OF DEATH

03346 Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 11 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINIA County GRANT
City or town PETERSBURG
(If outside city or town limits, write RURAL and give nearest town)
Street No. Central Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME HOMER B. LYNCH JR.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 26, 1929

8. AGE: Years 16 Months 3 Days 13 If less than one day hrs. min.

9. Birthplace W.VA., Gormania (Town, county, and state)

10. Usual occupation STUDENT

11. Industry or business

FATHER 12. Name HOMER B. LYNCH SR.
FATHER 13. Birthplace OHIO

MOTHER 14. Maiden name BERTIE FISHER
MOTHER 15. Birthplace W.VA.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/11/46 (month) (day) (year)
Cemetery or crematory Petersburg Cem.
Location Petersburg W. Va.

18. Funeral director Earl E. Bush
Address Petersburg W. Va.

19 April 9 1946 J.P. Franklin M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH APR. 9, 1946 at 8:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAR. 29, 1946, to APR. 9, 1946 and that I last saw h... im alive on APR. 9, 1946

	DURATION
Immediate cause of death Agranulocytic Angina	7 days
Due to	
Due to	
Other conditions Rheumatic Heart Disease	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op. None
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W.F. Williams M. D. or other
Address Cumberland Md. Date signed 4-9-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
APR 16 1946
BUREAU U.S.

Yester

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8a)

CERTIFICATE OF DEATH

03347 14

Reg. Dist. No. .....

I. PLACE OF DEATH:

County: Allegany

City or town: Corriganville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Corriganville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Frank Martz

3.(b) Social Security Number 217-10-6333A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ellender Mowry Martz

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): December 15, 1874

8. AGE: Years	Months	Days	If less than one day
71	3	19	..... hrs. ..... min.

9. Birthplace: Glencoe Pa. (Town, county, and state)

10. Usual occupation: Celanese employ

11. Industry or business

FATHER 12. Name: Noah Martz

13. Birthplace: Pa.

MOTHER 14. Maiden name: Mary Waugerman

15. Birthplace: Pa.

16. Informant: Mrs. Frank Martz

Address: Corriganville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 7, 1946 (month) (day) (year)

Cemetery ~~or crematory~~: Hyndman

Location: Hyndman

18. Funeral director: Harvey L. Engle

Address: Hyndman, Pa.

19. April 6 1946 J. Lloyd Wade

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 4 1946, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to March 15 1946 and that I last saw h.. alive on March 15 1946

Immediate cause of death: Cardiac renal	DURATION
Due to:	
Due to:	
Other conditions: Sclerosis of coronary arteries	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: D Kester M. D. or other

Address: 122 Bedford St Date signed: 4/4/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
APR 15 1946
BUREAU V.S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

03348

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: R.D.#5 Cumberland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D.#5 Cumberland
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Martin Martz

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth Martz
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 17, 1868

8. AGE: Years	Months	Days	If less than one day
77	10	12	hrs. min.

9. Birthplace: Cresaptown, Maryland (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: C. & P. Railroad
FATHER 12. Name: Peter Martz
13. Birthplace: Germany
MOTHER 14. Maiden name: Lollie Wigger
15. Birthplace: Holland
16. Informant: Mr. George Martz
Address: R.D.#5 Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1, 1946 (month) (day) (year)
Cemetery or crematory: S.S. Peter & Paul Cem.
Location: Cumberland, Md.
18. Funeral director: Charles L. George
Address: Cumberland, Md.
19. April 30, 1946. (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 29, 1946 at 6 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1945 to April 29, 1946
and that I last saw him alive on April 26, 1946

Immediate cause of death	DURATION
Congestive Heart failure	1 hr.
Due to: Myocardial Sclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Elizabeth Brinz M.D.
M. D. or other
Address: Lonaconing, Md. Date signed: 4/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
MAY 3 1946
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

03349

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:
County: Allegany
City or town: Mt Savage
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 64
Hospital, Institution, or street address where death occurred:
Main St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Mt Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Catherine L. McNamee

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 28 1881

8. AGE: Years 64 Months 8 Days 27 If less than one day: hrs. min.

9. Birthplace: Mt Savage Md
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

MOTHER / FATHER
12. Name: Francis McNamee
13. Birthplace: Pa.
14. Maiden name: Mary Meehan
15. Birthplace: Md.

16. Informant: Thomas J McNamee
Address: Mt Savage

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29-46 (month) (day) (year)
Cemetery or crematory: St Patricks Cem
Location: Mt Savage Md

18. Funeral director: Louis Steinbrecher
Address: Cumberland

19. 4/27-46 (Date rec'd by registrar) Vernina McDermott Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1946 at 10-15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24 1946 to April 25 1946 and that I last saw her alive on April 24 1946

Immediate cause of death	DURATION
Coronary Thrombosis	1
Due to	
Due to	
Other conditions: Moderate Arterio Hypertension & Sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William E. Moseley M. D. or other
Address: Mt Savage Md. Date signed 4/26-46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 7 1946
BUREAU V.A.

Within corporate limits

Whitworth

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (132)

CERTIFICATE OF DEATH

03350

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Flintstone
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. 2,
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Miss Amy Malinda Miller

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 26 1893

8. AGE:

Years	Months	Days	If less than one day
52	8	0	hrs. min.

9. Birthplace Beans Cove, Pa.
(Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

FATHER
12. Name Benton Miller
13. Birthplace Cumberland Valley, Pa.

MOTHER
14. Maiden name Annie Pryor
15. Birthplace Hancock, Md.

16. Informant Richard Miller
Address Rt. 2, Flintstone, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29, 1946 (month) (day) (year)

Cemetery or crematory Church of the Seven Dolors

Location Beans Cove, Pa.

18. Funeral director John J. Hooper

Address Cumberland, Md.

19. April 28, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1946, at 7:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 April 1946, to 26 April 1946 and that I last saw h.. alive on 25 April 46 1946

Immediate cause of death	DURATION
Uremia, due to Anuria	
Cause Undetermined. C.C.P.	
Due to Cause undetermined	
Physician only saw patient the day before	
Due to she died.	
No further information.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dudley B. Whitworth M. D. or other

Address 112 Bedford St. Date signed 27 April 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
APR 30 1946
BUREAU U. S.

Within corporate limits DR. C. I. OWENS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17

CERTIFICATE OF DEATH

03351

Reg. Diat. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County GARRETT
City or town CRELLIN
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
BABY GIRL, MOATES

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 8, 1946

8. AGE: Years | Months | Days 1 | If less than one day ... hrs. ... min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name CHARLES MOATES
13. Birthplace W.VA.

MOTHER
14. Maiden name STELLA MOATES
15. Birthplace W.VA.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 10, 1946 (month) (day) (year)
Cemetery or crematory Oakland Cem
Location Oakland, Md.

18. Funeral director Emory Golden
Address Oakland Md

19. April 10, 1946 (Date rec'd by registrar) J. F. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 9 1946 at 10:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9 1946 to April 9 1946
and that I last saw h... alive on April 9 1946

Immediate cause of death	DURATION
Prematurity	Hours
Due to	Only
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. L. Owens M.D. M. D. or other
Address Cumberland Md Date signed April 9-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
APR 16 1945
BUREAU V. S.

Outside of City limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

03352

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Long (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 weeks

Hospital, institution, or street address where death occurred: Near Cumberland, rural

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Penna County: Bedford

City or town: Artemas (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Minnie Florance Murphy

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife: George Murphy

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 17, 1871

8. AGE:

Years	Months	Days	If less than one day
75	0	15	hrs. min.

9. Birthplace: Artemas, Pa (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER 12. Name: Espey Bennett

13. Birthplace: Pa.

MOTHER 14. Maiden name: Hymes

15. Birthplace: Pa.

16. Informant: Mrs. Olive Scott

Address: Long, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 5 1946 (month) (day) (year)

Cemetery or crematory: Mt Hope Christian

Location: Artemas, Pa.

18. Funeral director: Harvey H. Feagley

Address: Hyndman, Pa.

19. April 4 1946 Hunter R. Darby M.D. Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2 1946, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4 1946 to April 2 1946

and that I last saw her alive on April 1 1946

	DURATION
Immediate cause of death: Chronic Arteritis	15 yrs.
Due to: Selective Heart Failure	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John A Topper M.D. M. D. or other

Address: Hyndman Pa. Date signed 4-3-46

RECEIVED
APR 9 1946
BUREAU V.S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

03353

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 years

Hospital, Institution, or street address where death occurred: 404 Central Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 404 Central Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Millard Gerome Myers

3. (b) Social Security Number: 705-09-3441

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Divorced

6.(b) Name of husband or wife: Pearl F. Smith

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): October 15, 1881

8. AGE:

Years	Months	Days	If less than one day
64	6	0	...hrs. ...min.

9. Birthplace: Araby, Frederick Md. (Town, county, and state)

10. Usual occupation: Machine operator

11. Industry or business: B & O Reclamation Plant

FATHER

12. Name: Mahlon L. Myers

13. Birthplace: Carrolls Manor, Md.

MOTHER

14. Maiden name: Martha Leather

15. Birthplace: Baltimore, Md.

16. Informant: Melissa Moore

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 17, 1946 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hoffer

Address: Cumberland Md.

19. April 16, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15, 1946, at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ...19..., to ...19...

and that I last saw h...alive on ...19...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Lewis H. Bowen, M.D. M. D. or other

Address: Cumberland, Maryland Date signed: 4-16-46

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEI
APR 23 1946
BUREAU V S

Outside of City Limits Schindler

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

03354

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Rural - Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, Institution, or street address where death occurred:
Rural - Cumberland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rt. 5 -
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Loretta Louise Neat

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife John Neat
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 18, 1884

8. AGE:	Years	Months	Days	If less than one day
	62	2	20	..... hrs. ..... min.

9. Birthplace Vale Summit Allegany Co. Md
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own home
FATHER 12. Name Thomas Higgins
13. Birthplace Ireland
MOTHER 14. Maiden name Mary Baxter
15. Birthplace Scotland
16. Informant Mary Alderton
Address Rt. 5, Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 11, 1946 (month) (day) (year)
Cemetery or crematory St. Michaels Cemetery
Location Frostburg, Md.
18. Funeral director John J. Hofer
Address Cumberland, Md.
19. April 11, 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1946, at 11:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 1946, to April 8 1946
and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Thrombosis	10 min.
Due to Generalized arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) ..... (County) ..... (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Blanche M. Schindler M.D.
M. D. or other
Address 141 Greene St. Date signed April 11, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
APR 16 1946
BUREAU V. M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

03355

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Alleg. Maryland
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
147 Washington St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Alleganey
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 147 Washington St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary Brown Patterson

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Patterson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 19, 1859

8. AGE: Years: 87 | Months: 2 | Days: 4 | If less than one day: hrs. min.

9. Birthplace: Scotland
(Town, county, and state)

10. Usual occupation: Home

11. Industry or business

FATHER
12. Name: William Brown
13. Birthplace: Scotland

MOTHER
14. Maiden name: Mary McFadden
15. Birthplace: Scotland

16. Informant: John Patterson
Address: Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 25-1946 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md.

18. Funeral director: J. J. Durst
Address: Frostburg, Md.

19. 4-25 1946 Mrs. Nancy H. Doe Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23 1946, at 6:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/19 1944 to 4/23 1946 and that I last saw h[illegible] alive on 4/22 1946

Immediate cause of death	DURATION
Gastro enteritis	2 days
Due to	
Due to	
Other conditions: arteriosclerosis, Prostatic Carcinoma	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hilda Jane Walters M.D.
M. D. or other
Address: [illegible] Frostburg Date signed: 4/25/46

RECEIVED
APR 27 1946
BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-d)

CERTIFICATE OF DEATH

03356

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 71 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 342 Baltimore Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Michael P. Pendergast

3.(b) Social Security Number: 714-10-7337

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 5, 1883

8. AGE: Years	Months	Days	If less than one day
63	—	29	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Employee
11. Industry or business: Celanese Corp.
FATHER 12. Name: Deceased Michael Pendergast
13. Birthplace: md
MOTHER 14. Maiden name: Deceased Delia Murphy
15. Birthplace: md
16. Informant: Mrs Agnes T Vansmissmithe
Address: Cumberland Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/6/46 (month) (day) (year)
Cemetery or crematory: St Peter & Paul Cem
Location: Cumberland, Md
18. Funeral director: Lewis Stein Inc
Address: Cumberland, Md
19. April 5 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 4 1946 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1945 to April 4, 1946 and that I last saw h... alive on 4-4-46 1946

Immediate cause of death	DURATION
Carcinoma of Rectum	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operation: Carcinoma Rectum
Date of op. April 1945
Autopsy results: Nor
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M.D.
M. D. or other
Address: [illegible] Date signed 4-5-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
APR 9 1946
BUREAU V.S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124)

03357

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 yrs.

Hospital, Institution, or street address where death occurred:
324 Emily St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 324 Emily St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Edward Reid

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 5 1911

8. AGE: Years 34 | Months 9 | Days 23 | If less than one day: hrs. min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: mill worker

11. Industry or business

FATHER 12. Name: George Reid

13. Birthplace: Md.

MOTHER 14. Maiden name: Ella Farrell

15. Birthplace: Md.

16. Informant: R Emmett Reid

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 1 46 (month) (day) (year)

Cemetery or crematory: St Patrick Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. April 30 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29 1946 at 7A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 1946 to April 29 1946 and that I last saw h.. alive on April 27 1946

Immediate cause of death	DURATION
Gastro-intestinal Hemmorrhage	9 days
Due to: Cirrhosis of the Liver	1 yr.
Due to: Chronic Alcoholism	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C O Nevaskas Jr. M. D. or other

Address: 230 Baltimore Ave Date signed: 4/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
MAY 3 1946
BUREAU V. M.

Within Corporate limits

DR. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-6)

CERTIFICATE OF DEATH

★ 03358

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 43 yrs.
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 128 OLD TOWN (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Lester Rice

3.(b) Social Security Number 214-05-8678

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	WHITE	MARRIED

6.(b) Name of husband or wife MARIE PHILLIPS

6.(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) MAY 1 1902

8. AGE: Years	Months	Days	If less than one day
43	11	6	hrs. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation PAINTER

11. Industry or business

FATHER 12. Name CHARLES RICE
13. Birthplace MARYLAND

MOTHER 14. Maiden name SARAH JOHNSON
15. Birthplace WEST VIRGINIA

16. Informant Carl E Phillips
Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 10 46 (month) (day) (year)
Cemetery or crematory Ort Herman Cem
Location Williams Rd.

18. Funeral director Lonie Stine Inc
Address Cumberland

19. April 10, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 7, 1946 19 4:55 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 19 46, to April 7 19 46
and that I last saw him alive on April 7, 1946 19

Immediate cause of death	DURATION
Nephritis Chronic	
Uremia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. J. Williams M.D.
M. D. or other
Address Md. Bldg. Cumberland Md Date signed 4/8/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

RECEIVED
APR 16 1946
BUREAU V S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

03359

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years

Hospital, institution, or street address where death occurred:

Sylvan Retreat

How long in hospital or institution? 11 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town 52 McCullough St Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 52 McCullough St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James Rizer

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 22, 1870

8. AGE: Years	Months	Days	If less than one day
76	1	18	..... hrs. ..... min.

9. Birthplace Frostburg, Allegany, Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business None

FATHER 12. Name Simon Rizer

13. Birthplace Frostburg, Md.

MOTHER 14. Maiden name Henrietta Holtzman

15. Birthplace Mt. Savage, Md.

16. Informant Arthur Rizer

Address Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 14 1946 (month) (day) (year)

Cemetery or crematory Percy Cemetery

Location Frostburg, Md.

18. Funeral director John J. Hofer

Address Cumberland Md.

19 April 14 19 46 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1946, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1 1946, to 4-10 1946 and that I last saw him alive on 4-10 1946.

Immediate cause of death	DURATION
Chronic Hypertrophic Degeneration	
Due to	
Due to	
Other conditions Generalized Arteriosclerosis.	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Wm. F. Williams M.D. (M.D. or other)

Address Cumberland Md. Date signed 4-12-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
APR 23 1945
BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

03360

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 yrs
Hospital, institution, or street address where death occurred: 415 Washington St.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 415 Washington St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Milnor Roberts

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Fanny Hollbrland
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Jan 21 1865

8. AGE:

Years	Months	Days	If less than one day
81	2	12	... hrs. ... min.

9. Birthplace: Brandon, Vt.
(Town, county, and state)
10. Usual occupation: Retired - Civil Mgr.
11. Industry or business: Electric Railways Co.
MOTHER FATHER
12. Name: Wm M. Roberts
13. Birthplace: Pa.
MOTHER
14. Maiden name: Elizabeth Hunsicker
15. Birthplace: Md
16. Informant: Frederick Roberts
Address: Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 4 46 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem
Location: Cumberland
18. Funeral director: Louis Stein Inc
Address: Cumberland
19. April 4 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2 1946 at 1:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 1946, to April 2 1946
and that I last saw him alive on April 2 1946
Immediate cause of death: Coronary Occlusion (Thrombosis) — Duration: 1 hour
Due to: Hypertension Cardiovascular Renal Disease — Duration: 2
Due to: Myocardial Degeneration — Duration: —
Other conditions: — Duration: —
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Samuel A Jacobson M.D. M. D. or other
Address: 15 Baltimore St Date signed: 4/3/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
APR 9 1946
BUREAU V.S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03361

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 minutes
Hospital, Institution, or street address where death occurred:
Five minutes in Allegany Hospital
How long in hospital or institution? Five minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: West Virginia County: Morgan
City or town: Paw Paw
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Baby boy Robertson – Joseph Lynn Robertson

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1946; at 8:23 A.M.

8. AGE: Years | Months | Days | If less than one day: hrs. 5 min.

9. Birthplace: Cumberland, Allegany Co., Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Lewis Robertson
13. Birthplace: W. Va.

MOTHER 14. Maiden name: Winifred Grace Skidmore
15. Birthplace: West Virginia

16. Informant: Lewis Robertson
Address: Paw Paw W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 3, 46 (month) (day) (year)
Cemetery or crematory: Camp Hill Cem.
Location: Paw Paw W. Va.

18. Funeral director: Lewis Stein Inc.
Address: Cumberland

19. April 3, 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2, 1946, at 8:23 A.M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from April 2, 1946 to April 2, 1946 and that I last saw h[illegible] alive on April 2, 1946

Immediate cause of death	DURATION
Asphyxia & Hemorrhage	5 min.
Due to: Prolonged foot Presentation	3 hrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. P. Franklin M. D. or other
Address: Cumberland Md. Date signed 4-2-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
APR. 9 1946.
BUREAU V.S.

Within corporate limits

DR. SCHINDLER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

213-~~22-~~2873

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 7 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State CUMBERLAND County ALLEGANY
City or town MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 408 BROADWAY
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MRS. AGNES ROBINSON

3.(b) Social Security Number 213-22-2873

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife MR. RAY ROBINSON
6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) SEPT. 16, 1905

8. AGE: Years	Months	Days	If less than one day
40	7	3	..... hrs. ..... min.

9. Birthplace OHIO (Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business
12. FATHER Name CHARLES MOUGRUNE.
13. FATHER Birthplace TENN.
14. MOTHER Maiden name FRANCES ARNOLD
15. MOTHER Birthplace TENN.
16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 20, 1946 (month) (day) (year)
Cemetery or crematory Queens Point Cemetery
Location Keyser, W. Va.
18. Funeral director William H. Kight
Address Cumberland, Maryland
19 April 20, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 19 19 46 at 1:02 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13 19 46 to April 19 19 46 and that I last saw h.. alive on April 18 19 46

Immediate cause of death	DURATION
Carcinoma Left Breast	2 Years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Blanche M. Schindler M.D. M. D. or other
Address 41 Greene St Cumberland, Md. Date signed April 19/1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
APR 23 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 106

03363

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 Mos. 8 Dys
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Detached
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME Hetta Marie Ross

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Child

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Dec. 20, 1945

8. AGE: Years	Months	Days	If less than one day
	4	8	..... hrs. ..... min.

9. Birthplace: Lonaconing, Allegany Co. Md.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business: —

FATHER
12. Name: Orville W. Ross
13. Birthplace: unknown

MOTHER
14. Maiden name: Edith Tennent
15. Birthplace: Lonaconing, Md

16. Informant: Mrs. James Tennent
Address: Lonaconing Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 30 '46 (month) (day) (year)
Cemetery or crematory: Laurel Hill Cemetery
Location: Mascot, Md

18. Funeral director: M. Eichhorn
Address: Lonaconing, Md

19. April 30 1946 (Date rec'd by registrar) D. E. Dowler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28 19 46, at 10:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28 19 46 to April 28 19 46 and that I last saw h[illegible] alive on April 28 19 46

Immediate cause of death	DURATION
Acute Tracheo-bronchitis	2 days
Due to	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work?

23. SIGNATURE: Norman Reeves M D (M. D. or other)
Address: Piedmont W Va Date signed 4-29-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MAY 2 1946
BUREAU V.S.

Within corporate limits

DR. ENFIELD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (27-a)

CERTIFICATE OF DEATH

03364

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or Institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State WEST VIRGINIA County MINERAL

City or town WILEY FORD
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME MRS. BERTHA LEMON RUMMER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife LEWIS UPTON RUMMER

6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Sept 1 1879

8. AGE: Years 66 | Months 7 | Days 9 | If less than one day ____ hrs. ____ min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name Joseph T. Wilkinson

13. Birthplace Md.

MOTHER 14. Maiden name Harriett

15. Birthplace Md

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 12 46 (month) (day) (year)

Cemetery or crematory Hillcrest Mem.

Location Cumberland.

18. Funeral director Louis Stein Inc

Address Cumberland

19. April 12 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 10 1946, at 6:45 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 7 1946, to April 10 1946

and that I last saw her alive on April 8 1946

Immediate cause of death	DURATION
Intussusception of Intestines	
Due to Tumor of Ileum	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. 4/7/46

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE A. E. Eldred M. D. or other

Address Cumberland Date signed 4/10/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-5M

RECEIVED
APR 16 1946
BUREAU V. R.

Within corporate limits

03365

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? Seven days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Crellin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME a.
Mrs. Mary^ Shaffer

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Albert W. Shaffer
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): August 31, 1902

8. AGE: Years: 43 | Months: 7 | Days: 9 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland, Hoyes, Garrett Co.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: John T. DeWitte
13. Birthplace: Maryland, Savg Run

MOTHER
14. Maiden name: Rebecca J. Thomas
15. Birthplace: Maryland, Savg Run

16. Informant: James K. Shaffer
Address: Crellin, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 7, 1946 (month) (day) (year)

Cemetery or crematory: Terra Alta Cem

Location: Terra Alta, W. Va.

18. Funeral director: Emroy Bolden

Address: Oakland, Md.

19. May 21, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 1946, at 12:08 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-27-46 19..., to 4-30- 1946

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Carcinoma of Gallbladder	
Due to Cholelithiasis,	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of gall-bladde with gall stones Date of op. 4-29-46

Autopsy results: - - - - -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John N. Brown M.D. M. D. or other

Address: Cumberland, Md. Date signed: 4-30-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
MAY 22 1946
BUREAU V. S.

Within corporate limits

D. Johnson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117-a)

CERTIFICATE OF DEATH

03366

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Allegany Hospital, Cumberland, Maryland

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 601 N. Mechanic St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Simmons, Mrs. Haddie Jane Simmons

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife Robert Simmons

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4/30/1894

8. AGE: Years	Months	Days	If less than one day
51	11	24	hrs. min.

9. Birthplace Petersburg, W. Va.
(Town, county, and state)

10. Usual occupation Owner - Rooming House

11. Industry or business

FATHER 12. Name George Landis

13. Birthplace W. Va.

MOTHER 14. Maiden name Hannah Kimble

15. Birthplace W. Va.

16. Informant Mrs Wilhelmina Brode

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 26 46 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland.

18. Funeral director Louis Stein Inc.

Address Cumberland.

19. April 26 1946 J. P. Franklin, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/24 (24) 1946 at 12:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23 1946 to April 24 1946 and that I last saw her alive on April 24 1946

Immediate cause of death	DURATION
Ruptured pyloric ulcer with general peritonitis	48 hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Ruptured pyloric ulcer with general peritonitis Date of op. 4-23-46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. J. Johnson Jr. M.D.
M. D. or other

Address Chamberlain MD Date signed 4-25-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
APR 30 1946
BUREAU OF S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

03367

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

605 Virginia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 605 Virginia Ave

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Percy Gordon Smith

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Lula Irma Holmes

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) April 21 1872

8. AGE: Years 73 | Months 11 | Days 12 | If less than one day ____ hrs. ____ min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Salesman

11. Industry or business Sewing machines

FATHER 12. Name Andrew Jackson Smith

13. Birthplace Va.

MOTHER 14. Maiden name Ellen Lemon

15. Birthplace Va.

16. Informant Mrs Lula Smith

Address 605 Virginia Ave

17. Burial & Rem. Date thereof March 6 1946
(Burial, cremation, or removal. Which?) Removal (month) (day) (year)

Cemetery or crematory Bedington Cem.

Location Bedington, Va.

18. Funeral director Davis Stein Inc

Address Cumberland, Md.

19. Apr 5 1946 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1946 at 2-10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15, 1946, to Apr. 3, 1946 and that I last saw h— alive on Apr. 2, 1946

Immediate cause of death	DURATION
Generalized Arteriosclerosis	2 yrs
Due to Uraemia	3 wks
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE Clay F. Turner M. D. or other

Address Cumberland, Md. Date signed Apr. 4-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
APR 9 1946
BUREAU V.S.

Within corporate limits MATHEWS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (246)

03368

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND? MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 yrs

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 27 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD. County ALLEG.

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Bruce St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James E. Bro[illegible] Stevens

3.(b) Social Security Number 214-05-7914

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife Helen Dressing

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) — 1898, Nov. 9

8. AGE: Years 47 Months 5 Days 10 If less than one day ... hrs. ... min.

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual occupation FIRES FURNACE

11. Industry or business Janitor

FATHER 12. Name STEVENS, William

13. Birthplace Maryland

MOTHER 14. Maiden name Nettie Nickel

15. Birthplace Maryland

16. Informant Mrs Mary G. Turner

Address 323 Bruce St. Cumberland

17. Burial (Burial, cremation, or removal? Which?) Date thereof Apr 23 46 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. April 23, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 19, 1946 at 10:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 24 1946 to April 19 1946 and that I last saw him alive on April 19 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE L. H. Hoskins M. D. or other

Address 49 Greene St Date signed 4/20/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
APR 30 1946
BUREAU V.S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (HD)

CERTIFICATE OF DEATH

03369

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 72yrs.
Hospital, Institution, or street address where death occurred:
George St. Cumberland, Md.
How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 436 Chesnut st.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Joseph Clarence Stewart

3.(b) Social Security Number 213-18-2470

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Laura Louise Wilkes
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 1873

8. AGE: Years 72 | Months 6 | Days — | If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland, Allegany, Maryland
(Town, county, and state)

10. Usual occupation Engineer

11. Industry or business W.M. R.R.

FATHER
12. Name George Minard
13. Birthplace Md.

MOTHER
14. Maiden name Marion Johnson
15. Birthplace Md.

16. Informant Cheston Stewart
Address 436 Chesnut St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 5 1946 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetary
Location Cumberland, Md.

18. Funeral director Louis Stein, Inc.
Address Cumberland, Md.

19. April 3 1946 (Date rec'd by registrar) J.P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2nd, 1946 at 1.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary Occlusion	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results: noautopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Prince H. Bowman M.D.
M. D. or other
Address Cumberland, Maryland Date signed 4-2-46

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
APR 9 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

03370

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Mt Lothian

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Mt Lothian Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Chas Michael Figlee

3.(b) Social Security Number 213-09-6619

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21 1878

8. AGE:

Years	Months	Days	If less than one day
67	9	24	hrs. min.

9. Birthplace Mt Lothian Allegany Md.

(Town, county, and state)

10. Usual occupation Retired Miner

11. Industry or business Consol Coal Co.

FATHER 12. Name John P. Figlee

13. Birthplace England

MOTHER 14. Maiden name Magdeline Keller

15. Birthplace New Germany, Md.

16. Informant Mrs Edna M. Logan

Address Mt Lothian, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-17-1946 (month) (day) (year)

Cemetery or crematory St Michaels Cem.

Location Frostburg, Md.

18. Funeral director Jacob Yates

Address Frostburg, Md.

19. 4-16 1946 Della Nancy H. Roe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1946, at 1.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sudden death 19

and that I last saw h alive on 19

Immediate cause of death Coronary Thrombosis — DURATION: Sudden

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W M Lane M.D.

M. D. or other

Address Frostburg Md Date signed 4-16-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
APR 18 1946
BUREAU V. R.

Within corporate limits

03371

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24-B)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 73 yrs.

Hospital, institution, or street address where death occurred: 103 S Centre St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 103 S Centre St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George William Trapell

3.(b) Social Security Number 705-07-9507

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Ella Crothers

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 3 1872

8. AGE: Years	Months	Days	If less than one day
73	11	27	..... hrs. ..... min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Railroad Brakeman

11. Industry or business Retired 8 yrs

FATHER 12. Name Thomas Trapell

13. Birthplace Maryland

MOTHER 14. Maiden name Mary McCraig

15. Birthplace Maryland

16. Informant Mrs Jodie Ann Smith

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 2 46 (month) (day) (year)

Cemetery or crematory St Patricks Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. May 1, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1946 at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-1-45 19.. to ..... 19.. and that I last saw h.. alive on 4-29-46 19..

Immediate cause of death	DURATION
Chr. Myocarditis	1 yr.
Due to	
Due to	
Other conditions Cirrhosis Liver	6 mo.

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE G C Summers M. D. or other

Address ..... Date signed 4-30-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
MAY 3 1946
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1190)

CERTIFICATE OF DEATH

★ 03372

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany Christie Road

City or town ~~Baltimore Pike~~ Near Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, Institution, or street address where death occurred:

Christie Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Near Cumberland, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Christie Road, Rt #2

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Marcellis Lynn Wentling

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Infant

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 23, 1945

8. AGE: Years	Months	Days	If less than one day
0	4	27	..... hrs. ..... min.

9. Birthplace Cumberland, Allegany Co Md (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name Louis Wentling

FATHER 13. Birthplace Williams Road Alleg Co

MOTHER 14. Maiden name Gertrude "Stegmaier" Wentling

MOTHER 15. Birthplace Williams Rd. Alleg. Co.

16. Informant Louis Wentling

Address 6 Christie Road Cumb Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 23, 1946 (month) (day) (year)

Cemetery or crematory Mt Herman Cemetery

Location Near Cumberland Md

18. Funeral director John J Hafer

Address Cumberland Md.

19. April 23 1946 (Date rec'd by registrar) J. L. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1946, at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18 1946 to April 20 1946

and that I last saw h[illegible] alive on April 20 1946

Immediate cause of death	DURATION
Bronchopneumonia	3 days
Due to Contra Calves	about 10 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M & D Owens M.D. M. D. or other

Address 133 Va Ave Date signed 4/23/46.

RECEIVED
APR 30 1946
BUREAU V.S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

03373

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
725 N. Mechanic St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 725 N. Mechanic St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James Whitacre

3.(b) Social Security Number: 705-10-8547

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

B.(b) Name of husband or wife: Helen F. Whitacre
B.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 25, 1884

8. AGE: Years	Months	Days	If less than one day
62	0	25	..... hrs. ..... min.

9. Birthplace: Hyndman, Pa.
(Town, county, and state)
10. Usual occupation: Retired Brakeman
11. Industry or business: W. Md R.R. Co.

FATHER
12. Name: Joseph Whitacre
13. Birthplace: Penna.

MOTHER
14. Maiden name: Amanda Butts
15. Birthplace: Penna.

16. Informant: Mr. Charles Whitacre
Address: 725 N. Mechanic St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 22, 1946 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland, Md.
18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. April 22, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19th., 1946, at 10.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Prince H. Bowers, M.D.
M. D. or other
Address: Cumberland, Maryland Date signed: 4-20-46.

Deputy Medical Examiner - Allegany Co.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
APR 30 1946
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32d)

CERTIFICATE OF DEATH

03374

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred: 721 Fayette St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 721 Fayette St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bridget Sarah White

3.(b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~ John T. White

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 14 1876

8. AGE:

Years	Months	Days	If less than one day
69	7	24	..... hrs. ..... min.

9. Birthplace Ocean End. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business or None.

FATHER

12. Name Timothy Byrne

13. Birthplace Ireland

MOTHER

14. Maiden name Sarah Cullen

15. Birthplace Ireland

16. Informant James T. White

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 11 46 (month) (day) (year)

Cemetery or crematory St Patricks Cem.

Location Cumberland.

18. Funeral director Louis Stein Inc

Address Cumberland

19. April 10, 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1946 at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 8 1946 to Mar. 8 1946

and that I last saw her alive on Mar. 8 1946

Immediate cause of death	DURATION
Myocardial failure	2 yrs
Due to Hypertension cardio vascular disease	15 yrs
Due to Graves disease (Thyroidectomy 15 yrs or more ago)	15+ yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE Arthur F. James M. D.

M. D. or other

Address 122 Bedford St. Date signed 4-9-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
APR 16 1946
BUREAU V. S.

Within corporate limits

DR. W. WILLIAMS

03375

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 4 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINIA County GRANT
City or town PETERSBURG
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MR. JASPER WHITMER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife SUSAN STRAYMAN
6.(c) If alive, give age 73 years
7. Birth date of deceased (mo., day, yr.) ~~JULY~~ June 12 1873

8. AGE: Years	Months	Days	If less than one day
72	9	29	hrs. min.

9. Birthplace WEST VIRGINIA (Town, county, and state)
10. Usual occupation UNABLE TO WORK
11. Industry or business

FATHER
12. Name ~~SAMUEL WHITMER~~ Selestine Whitmer
13. Birthplace W. Va.

MOTHER
14. Maiden name Susan Delawder
15. Birthplace W. Va.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/13/46 (month) (day) (year)
Cemetery or crematory Petersburg Cem.
Location Petersburg W. Va.

18. Funeral director Earle Bush
Address Petersburg W. Va.

19. April 13, 46 J. P. Franklin, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1946 at 2:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4. 9. 46 to 4. 11. 46
and that I last saw him alive on 4 11 46

Immediate cause of death	DURATION
Intermittent Hemorrhages	
Generalized Arteriosclerosis.	
Due to	
Due to	
Other conditions Diabetes Mellitus.	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op. None
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other
Address Cumberland Date signed 4-11-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
APR 16 1946
BUREAU V. R.

Within corporate limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03376

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred: 718 Oldtown Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 718 Oldtown Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Marian Emma Wiebel

3.(b) Social Security Number 219-14-7305

4. Sex F

5. Color or race W

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) September 13, 1925

8. AGE: Years 20 Months 6 Days 25 If less than one day ... hrs. ... min.

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual occupation Clerical work

11. Industry or business K. S. Tire Co.

FATHER

12. Name Frank Wiebel

13. Birthplace Cumberland, Md.

MOTHER

14. Maiden name Hazel Perry

15. Birthplace Cumberland, Md.

16. Informant Frank Wiebel

Address 718 Oldtown Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 10, 1946 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. April 10, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1946, at 12:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1943, to April 8 1946 and that I last saw her alive on April 8 1946

Immediate cause of death Hodgkins Disease — DURATION 7 yrs.

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

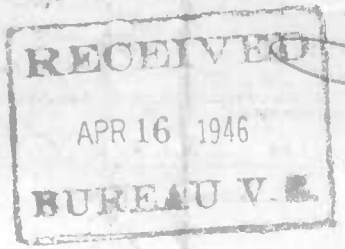
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE [signature] M. D. or other

Address 136 Union St. Cumberland, Md. Date signed 4/10/46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Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

03377

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years.

Hospital, Institution, or street address where death occurred: Police Station Jail

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No.: 2 Bedford at (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Albert Wiley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Married

6.(b) Name of husband or wife: Florence White

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct 14 1888

8. AGE: Years	Months	Days	If less than one day
57	5	18	..... hrs. ..... min.

9. Birthplace: Glenn Lyn Va. (Town, county, and state)

10. Usual occupation: Barber

11. Industry or business: Barber Shop.

FATHER 12. Name: Chas W. Riley

13. Birthplace: Hunterd Co Va.

MOTHER 14. Maiden name: Mantippa Hall

15. Birthplace: Grubbs, Tenn

16. Informant: Rusel W. Wiley

Address: 327 Va Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 6 46 (month) (day) (year)

Cemetery or crematory: Ivon memorial

Location: Near Cumberland, Md

18. Funeral director: Louis Stein Inc

Address: Cumberland Md

19. April 5, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH: April 2nd, 1946, at 11.05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....., 19....., to ....., 19.....

and that I last saw h..... alive on ....., 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions: Acute Alcoholism	

(Include pregnancy within 3 months of death)

Major findings of operations: ----

Date of op.:

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Prince H. Dawson, M.D. M. D. or other

Address: Cumberland, Maryland. Date signed: 4-3-46

Deputy Medical Examiner - Allegany Co.

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Within corporate limits ✓

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4id

CERTIFICATE OF DEATH

03378 ★ Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 31 Virginia Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mr. Lawrence A. Williams

3.(b) Social Security Number: 214-05-4218

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Pauline Williams
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 12, 1908

8. AGE: Years	Months	Days	If less than one day
~~38~~ 37	6	24	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Patrolman
11. Industry or business: Cumberland Police Dept.
FATHER 12. Name: John Williams
13. Birthplace: Germany
MOTHER 14. Maiden name: Margaret Neibauer
15. Birthplace: Germany
16. Informant: Pauline Williams
Address: Cumberland Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 9, 1946 (month) (day) (year)
Cemetery or crematory: St. Mary's
Location: Cumberland Maryland
18. Funeral director: Harvey H. Z. Yoder
Address: Hyndsford, Penna.
19. April 8, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6, 1946, at 6 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15, 1946, to 4-6-1946 and that I last saw him alive on 4-5-46, 19

Immediate cause of death	DURATION
Carcinoma Rectum	14 mos.
Due to	
Due to	
Other conditions: Coronary embolism	5 days

(Include pregnancy within 3 months of death)
Major findings of operations: Carcinoma Rectum
Date of op. 3-30-46
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. J. Zimmerman M.D.
M. D. or other
Address: Date signed 4-8-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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APR 16 1946
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Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9-2)

CERTIFICATE OF DEATH

★ 03379

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred: 215 Talghman St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 715 Talghman St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Annie Louise Williamson

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Albert G Williamson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 21 1848

8. AGE:

Years	Months	Days	If less than one day
97	7	4	..... hrs. ..... min.

9. Birthplace: Garrett Co Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

MOTHER FATHER

12. Name: Elisha Fuller

13. Birthplace: Md.

MOTHER

14. Maiden name: Sarah Ann Brown

15. Birthplace: Md.

16. Informant: Margaret L Reid

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 27 46 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. 4/27/46 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25 1946, at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935 to Apr. 25 1946 and that I last saw her alive on Mar. 21 1946

Immediate cause of death	DURATION
Myocardial Failure	12 hrs.
Due to: Old Age	97½ yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Arthur T. Jones M.D. M. D. or other

Address: 110 S. Centre St. Date signed 4-26-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15 9-45-15M

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APR 30 1946
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